(B) the volume and frequency of the conduct that would be identified in the special fraud alert.

(Aug. 14, 1935, ch. 531, title XI, § 1128D, as added Pub. L. 104–191, title II, § 205, Aug. 21, 1996, 110 Stat. 2000; amended Pub. L. 105–33, title IV, § 4331(a)(1), Aug. 5, 1997, 111 Stat. 395; Pub. L. 105–277, div. J, title V, § 5201(c), Oct. 21, 1998, 112 Stat. 2681–917; Pub. L. 106–554, § 1(a)(6) [title V, § 543], Dec. 21, 2000, 114 Stat. 2763, 2763A–551.)

REFERENCES IN TEXT

Section 14(a) of the Medicare and Medicaid Patient and Program Protection Act of 1987, referred to in subsec. (a)(1)(A)(i), is section 14(a) of Pub. L. 100–93, which is set out as a note under section 1320a–7b of this title.

Section 5 of the Inspector General Act of 1978, referred to in subsec. (a)(1)(C), is section 5 of Pub. L. 95–452, Oct. 12, 1978, 92 Stat. 1103, as amended, which is set out in the Appendix to Title 5, Government Organization and Employees.

The Internal Revenue Code of 1986, referred to in subsec. (b)(3)(B), is classified generally to Title 26, Internal Revenue Code.

AMENDMENTS

2000—Subsec. (b)(6). Pub. L. 106–554 struck out '', and before the date which is 4 years after August 21, 1996'' before period at end.

1998—Subsec. (b)(2)(A). Pub. L. 105–277 inserted ''or section 1320a–7a(i)(6) of this title'' before period at end.

1997—Subsec. (b)(2)(D). Pub. L. 105–33 substituted ''section 1320a–7a(b)'' for ''section 1320a–7b(b)''.

EFFECTIVE DATE OF 1997 AMENDMENT

Amendment by Pub. L. 105–33 effective as if included in the enactment of the Health Insurance Portability and Accountability Act of 1996, Pub. L. 104–191, see section 4331(f) of Pub. L. 105–33, set out as a note under section 1320a–7e of this title.

§ 1320a–7e. Health care fraud and abuse data collection program

(a) In general

The Secretary shall maintain a national health care fraud and abuse data collection program under this section for the reporting of certain final adverse actions (not including settlements in which no findings of liability have been made) against health care providers, suppliers, or practitioners as required by subsection (b), with access as set forth in subsection (d), and shall furnish the information collected under this section to the National Practitioner Data Bank established pursuant to the Health Care Quality Improvement Act of 1986 (42 U.S.C. 11101 et seq.).

(b) Reporting of information

(1) In general

Each Government agency and health plan shall report any final adverse action (not including settlements in which no findings of liability have been made) taken against a health care provider, supplier, or practitioner.

(2) Information to be reported

The information to be reported under paragraph (1) includes:

(A) The name and TIN (as defined in section 7701(a)(41) of the Internal Revenue Code of 1986) of any health care provider, supplier, or practitioner who is the subject of a final adverse action.

(B) The name (if known) of any health care entity with which a health care provider, supplier, or practitioner, who is the subject of a final adverse action, is affiliated or associated.

(C) The nature of the final adverse action and whether such action is on appeal.

(D) A description of the acts or omissions and injuries upon which the final adverse action was based, and such other information as the Secretary determines by regulation is required for appropriate interpretation of information reported under this section.

(3) Confidentiality

In determining what information is required, the Secretary shall include procedures to assure that the privacy of individuals receiving health care services is appropriately protected.

(4) Timing and form of reporting

The information required to be reported under this subsection shall be reported regularly (but not less often than monthly) and in such form and manner as the Secretary prescribes. Such information shall first be required to be reported on a date specified by the Secretary.

(5) To whom reported

The information required to be reported under this subsection shall be reported to the Secretary.

(6) Sanctions for failure to report

(A) Health plans

Any health plan that fails to report information on an adverse action required to be reported under this subsection shall be subject to a civil money penalty of not more than $25,000 for each such adverse action not reported. Such penalty shall be imposed and collected in the same manner as civil money penalties under subsection (a) of section 1320a–7a of this title are imposed and collected under that section.

(B) Governmental agencies

The Secretary shall provide for a publication of a public report that identifies those Government agencies that have failed to report information on adverse actions as required to be reported under this subsection.

(c) Disclosure and correction of information

(1) Disclosure

With respect to the information about final adverse actions (not including settlements in which no findings of liability have been made) reported to the Secretary under this section with respect to a health care provider, supplier, or practitioner, the Secretary shall, by regulation, provide for—

(A) disclosure of the information, upon request, to the health care provider, supplier, or licensed practitioner, and

(B) procedures in the case of disputed accuracy of the information.

(2) Corrections

Each Government agency and health plan shall report corrections of information already

reported about any final adverse action taken against a health care provider, supplier, or practitioner, in such form and manner that the Secretary prescribes by regulation.

(d) Access to reported information

(1) Availability

The information collected under this section shall be available from the National Practitioner Data Bank to the agencies, authorities, and officials which are provided under section 1396r–2(b) of this title information reported under section 1396r–2(a) of this title.

(2) Fees for disclosure

The Secretary may establish or approve reasonable fees for the disclosure of information under this section. The amount of such a fee may not exceed the costs of processing the requests for disclosure and of providing such information. Such fees shall be available to the Secretary to cover such costs.

(e) Protection from liability for reporting

No person or entity, including the agency designated by the Secretary in subsection (b)(5) of this section shall be held liable in any civil action with respect to any report made as required by this section, without knowledge of the falsity of the information contained in the report.

(f) Appropriate coordination

In implementing this section, the Secretary shall provide for the maximum appropriate coordination with part B of the Health Care Quality Improvement Act of 1986 (42 U.S.C. 11131 et seq.) and section 1396r–2 of this title.

(g) Definitions and special rules

For purposes of this section:

(1) Final adverse action

(A) In general

The term ''final adverse action'' includes:

(i) Civil judgments against a health care provider, supplier, or practitioner in Federal or State court related to the delivery of a health care item or service.

(ii) Federal or State criminal convictions related to the delivery of a health care item or service.

(iii) Actions by Federal agencies responsible for the licensing and certification of health care providers, suppliers, and licensed health care practitioners, including—

(I) formal or official actions, such as revocation or suspension of a license (and the length of any such suspension), reprimand, censure or probation,

(II) any dismissal or closure of the proceedings by reason of the provider, supplier, or practitioner surrendering their license or leaving the State or jurisdiction[1]

(III) any other loss of license or the right to apply for, or renew, a license of the provider, supplier, or practitioner, whether by operation of law, voluntary surrender, non-renewability, or otherwise, or

(IV) any other negative action or finding by such Federal agency that is publicly available information.

(iv) Exclusion from participation in a Federal health care program (as defined in section 1320a–7b(f) of this title).

(v) Any other adjudicated actions or decisions that the Secretary shall establish by regulation.

(B) Exception

The term does not include any action with respect to a malpractice claim.

(2) Practitioner

The terms ''licensed health care practitioner'', ''licensed practitioner'', and ''practitioner'' mean, with respect to a State, an individual who is licensed or otherwise authorized by the State to provide health care services (or any individual who, without authority holds himself or herself out to be so licensed or authorized).

(3) Government agency

The term ''Government agency'' shall include:

(A) The Department of Justice.

(B) The Department of Health and Human Services.

(C) Any other Federal agency that either administers or provides payment for the delivery of health care services, including, but not limited to the Department of Defense and the Department of Veterans Affairs.

(D) Federal agencies responsible for the licensing and certification of health care providers and licensed health care practitioners.

(4) Health plan

The term ''health plan'' has the meaning given such term by section 1320a–7c(c) of this title.

(5) Determination of conviction

For purposes of paragraph (1), the existence of a conviction shall be determined under paragraphs (1) through (4) of section 1320a–7(i) of this title.

(Aug. 14, 1935, ch. 531, title XI, §1128E, as added Pub. L. 104–191, title II, §221(a), Aug. 21, 1996, 110 Stat. 2009; amended Pub. L. 105–33, title IV, §4331(a)(2), (b), (d), Aug. 5, 1997, 111 Stat. 395, 396; Pub. L. 111–148, title VI, §6403(a), Mar. 23, 2010, 124 Stat. 763.)

REFERENCES IN TEXT

The Health Care Quality Improvement Act of 1986, referred to in subsecs. (a) and (f), is title IV of Pub. L. 99–660, Nov. 14, 1986, 100 Stat. 3784, which is classified generally to chapter 117 (§11101 et seq.) of this title. Part B of the Act is classified generally to subchapter II (§11131 et seq.) of chapter 117 of this title. For complete classification of this Act to the Code, see Short Title note set out under section 11101 of this title and Tables.

The Internal Revenue Code of 1986, referred to in subsec. (b)(2)(A), is classified generally to Title 26, Internal Revenue Code.

AMENDMENTS

2010—Subsec. (a). Pub. L. 111–148, §6403(a)(1), added subsec. (a) and struck out former subsec. (a). Prior to

[1] So in original. Probably should be followed by a comma.

amendment, text read as follows: ''Not later than January 1, 1997, the Secretary shall establish a national health care fraud and abuse data collection program for the reporting of final adverse actions (not including settlements in which no findings of liability have been made) against health care providers, suppliers, or practitioners as required by subsection (b) of this section, with access as set forth in subsection (c) of this section, and shall maintain a database of the information collected under this section.''

Subsec. (d). Pub. L. 111–148, § 6403(a)(2), added subsec. (d) and struck out former subsec. (d). Prior to amendment, text read as follows:

''(1) AVAILABILITY.—The information in the database maintained under this section shall be available to Federal and State government agencies and health plans pursuant to procedures that the Secretary shall provide by regulation.

''(2) FEES FOR DISCLOSURE.—The Secretary may establish or approve reasonable fees for the disclosure of information in such database (other than with respect to requests by Federal agencies). The amount of such a fee shall be sufficient to recover the full costs of operating the database. Such fees shall be available to the Secretary or, in the Secretary's discretion to the agency designated under this section to cover such costs.''

Subsec. (f). Pub. L. 111–148, § 6403(a)(3), added subsec. (f) and struck out former subsec. (f). Prior to amendment, text read as follows: ''The Secretary shall implement this section in such a manner as to avoid duplication with the reporting requirements established for the National Practitioner Data Bank under the Health Care Quality Improvement Act of 1986 (42 U.S.C. 11101 et seq.).''

Subsec. (g)(1)(A)(iii). Pub. L. 111–148, § 6403(a)(4)(A)(i)(I), struck out ''or State'' after ''Federal'' in introductory provisions.

Subsec. (g)(1)(A)(iii)(II). Pub. L. 111–148, § 6403(a)(4)(A)(i)(III), added subcl. (II).

Subsec. (g)(1)(A)(iii)(III). Pub. L. 111–148, § 6403(a)(4)(A)(i)(II), redesignated subcl. (II) as (III). Former subcl. (III) redesignated (IV).

Pub. L. 111–148, § 6403(a)(4)(A)(i)(I), struck out ''or State'' after ''Federal''.

Subsec. (g)(1)(A)(iii)(IV). Pub. L. 111–148, § 6403(a)(4)(A)(i)(II), redesignated subcl. (III) as (IV).

Subsec. (g)(1)(A)(iv). Pub. L. 111–148, § 6403(a)(4)(A)(ii), added cl. (iv) and struck out former cl. (iv) which read as follows: ''Exclusion from participation in Federal or State health care programs (as defined in sections 1320a–7b(f) and 1320a–7(h) of this title, respectively).''

Subsec. (g)(3)(D). Pub. L. 111–148, § 6403(a)(4)(C), which directed amendment of subpar. (D) of subsec. (g) by striking out ''or State'', was executed by striking out ''or State'' after ''Federal'' in subpar. (D) of subsec. (g)(3) to reflect the probable intent of Congress.

Pub. L. 111–148, § 6403(a)(4)(B), redesignated subpar. (F) as (D) and struck out former subpar. (D) which read as follows: ''State law enforcement agencies.''

Subsec. (g)(3)(E). Pub. L. 111–148, § 6403(a)(4)(B)(i), struck out subpar. (E) which read as follows: ''State medicaid fraud control units.''

Subsec. (g)(3)(F). Pub. L. 111–148, § 6403(a)(4)(B)(ii), redesignated subpar. (F) as (D).

1997—Subsec. (b)(6). Pub. L. 105–33, § 4331(d), added par. (6).

Subsec. (g)(3)(C). Pub. L. 105–33, § 4331(a)(2), substituted ''Department of Veterans Affairs'' for ''Veterans' Administration''.

Subsec. (g)(5). Pub. L. 105–33, § 4331(b), substituted ''paragraphs (1) through (4)'' for ''paragraph (4)''.

EFFECTIVE DATE OF 1997 AMENDMENT

Pub. L. 105–33, title IV, § 4331(f), Aug. 5, 1997, 111 Stat. 396, provided that:

''(1) IN GENERAL.—Except as provided in this subsection, the amendments made by this section [amending this section and sections 1320a–7, 1320a–7a, and 1320a–7d of this title] shall be effective as if included in the enactment of the Health Insurance Portability and Accountability Act of 1996 [Pub. L. 104–191].

''(2) FEDERAL HEALTH PROGRAM.—The amendments made by subsection (c) [amending section 1320a–7 of this title] shall take effect on the date of the enactment of this Act [Aug. 5, 1997].

''(3) SANCTION FOR FAILURE TO REPORT.—The amendment made by subsection (d) [amending this section] shall apply to failures occurring on or after the date of the enactment of this Act.''

TRANSITION PROCESS; REGULATIONS; EFFECTIVE DATE OF 2010 AMENDMENT

Pub. L. 111–148, title VI, § 6403(d), Mar. 23, 2010, 124 Stat. 766, provided that:

''(1) IN GENERAL.—Effective on the date of enactment of this Act [Mar. 23, 2010], the Secretary of Health and Human Services (in this section referred to as the 'Secretary') shall implement a transition process under which, by not later than the end of the transition period described in paragraph (5), the Secretary shall cease operating the Healthcare Integrity and Protection Data Bank established under section 1128E of the Social Security Act [42 U.S.C. 1320a–7e] (as in effect before the effective date specified in paragraph (6)) and shall transfer all data collected in the Healthcare Integrity and Protection Data Bank to the National Practitioner Data Bank established pursuant to the Health Care Quality Improvement Act of 1986 (42 U.S.C. 11101 et seq.). During such transition process, the Secretary shall have in effect appropriate procedures to ensure that data collection and access to the Healthcare Integrity and Protection Data Bank and the National Practitioner Data Bank are not disrupted.

''(2) REGULATIONS.—The Secretary shall promulgate regulations to carry out the amendments made by subsections (a) and (b) [amending this section and section 1396r–2 of this title].

''(3) FUNDING.—

''(A) AVAILABILITY OF FEES.—Fees collected pursuant to section 1128E(d)(2) of the Social Security Act [42 U.S.C. 1320a–7e(d)(2)] prior to the effective date specified in paragraph (6) for the disclosure of information in the Healthcare Integrity and Protection Data Bank shall be available to the Secretary, without fiscal year limitation, for payment of costs related to the transition process described in paragraph (1). Any such fees remaining after the transition period is complete shall be available to the Secretary, without fiscal year limitation, for payment of the costs of operating the National Practitioner Data Bank.

''(B) AVAILABILITY OF ADDITIONAL FUNDS.—In addition to the fees described in subparagraph (A), any funds available to the Secretary or to the Inspector General of the Department of Health and Human Services for a purpose related to combating health care fraud, waste, or abuse shall be available to the extent necessary for operating the Healthcare Integrity and Protection Data Bank during the transition period, including systems testing and other activities necessary to ensure that information formerly reported to the Healthcare Integrity and Protection Data Bank will be accessible through the National Practitioner Data Bank after the end of such transition period.

''(4) SPECIAL PROVISION FOR ACCESS TO THE NATIONAL PRACTITIONER DATA BANK BY THE DEPARTMENT OF VETERANS AFFAIRS.—

''(A) IN GENERAL.—Notwithstanding any other provision of law, during the 1-year period that begins on the effective date specified in paragraph (6), the information described in subparagraph (B) shall be available from the National Practitioner Data Bank to the Secretary of Veterans Affairs without charge.

''(B) INFORMATION DESCRIBED.—For purposes of subparagraph (A), the information described in this subparagraph is the information that would, but for the amendments made by this section [amending this section and sections 1320a–7c and 1396r–2 of this title], have been available to the Secretary of Veterans Affairs from the Healthcare Integrity and Protection Data Bank.

''(5) TRANSITION PERIOD DEFINED.—For purposes of this subsection, the term 'transition period' means the period that begins on the date of enactment of this Act [Mar. 23, 2010] and ends on the later of—

''(A) the date that is 1 year after such date of enactment; or

''(B) the effective date of the regulations promulgated under paragraph (2).

''(6) EFFECTIVE DATE.—The amendments made by subsections (a), (b), and (c) [amending this section and sections 1320a–7c and 1396r–2 of this title] shall take effect on the first day after the final day of the transition period.''

§ 1320a–7f. Coordination of medicare and medicaid surety bond provisions

In the case of a home health agency that is subject to a surety bond requirement under subchapter XVIII of this chapter and subchapter XIX of this chapter, the surety bond provided to satisfy the requirement under one such subchapter shall satisfy the requirement under the other such subchapter so long as the bond applies to guarantee return of overpayments under both such subchapters.

(Aug. 14, 1935, ch. 531, title XI, § 1128F, as added Pub. L. 106–113, div. B, § 1000(a)(6) [title III, § 304(b)], Nov. 29, 1999, 113 Stat. 1536, 1501A–361.)

§ 1320a–7g. Funds to reduce medicaid fraud and abuse

(1) In general

For purposes of reducing fraud and abuse in the Medicaid program under title XIX of the Social Security Act [42 U.S.C. 1396 et seq.]—

(A) there is appropriated to the Office of the Inspector General of the Department of Health and Human Services, out of any money in the Treasury not otherwise appropriated, $25,000,000, for fiscal year 2009; and

(B) there is authorized to be appropriated to such Office $25,000,000 for fiscal year 2010 and each subsequent fiscal year.

Amounts appropriated under this section shall remain available for expenditure until expended and shall be in addition to any other amounts appropriated or made available to such Office for such purposes with respect to the Medicaid program.

(2) Annual report

Not later than September 30 of 2009 and of each subsequent year, the Inspector General of the Department of Health and Human Services shall submit to the Committees on Energy and Commerce and Appropriations of the House of Representatives and the Committees on Finance and Appropriations of the Senate a report on the activities (and the results of such activities) funded under paragraph (1) to reduce waste, fraud, and abuse in the Medicaid program under title XIX of the Social Security Act [42 U.S.C. 1396 et seq.] during the previous 12 month period, including the amount of funds appropriated under such paragraph for each such activity and an estimate of the savings to the Medicaid program resulting from each such activity.

(Pub. L. 110–252, title VII, § 7001(b), June 30, 2008, 122 Stat. 2389.)

REFERENCES IN TEXT

The Social Security Act, referred to in text, is act Aug. 14, 1935, ch. 531, 49 Stat. 620. Title XIX of the Act is classified generally to subchapter XIX (§ 1396 et seq.) of this chapter. For complete classification of this Act to the Code, see section 1305 of this title and Tables.

This section, referred to in par. (1), means section 7001 of Pub. L. 110–252, which enacted this section and section 1396w of this title, amended sections 1396a and 1396b of this title, and repealed provisions set out as a note under section 1396a of this title.

CODIFICATION

Section was enacted as part of the Supplemental Appropriations Act, 2008, and not as part of the Social Security Act which comprises this chapter.

§ 1320a–7h. Transparency reports and reporting of physician ownership or investment interests

(a) Transparency reports

(1) Payments or other transfers of value

(A) In general

On March 31, 2013, and on the 90th day of each calendar year beginning thereafter, any applicable manufacturer that provides a payment or other transfer of value to a covered recipient (or to an entity or individual at the request of or designated on behalf of a covered recipient), shall submit to the Secretary, in such electronic form as the Secretary shall require, the following information with respect to the preceding calendar year:

(i) The name of the covered recipient.

(ii) The business address of the covered recipient and, in the case of a covered recipient who is a physician, the specialty and National Provider Identifier of the covered recipient.

(iii) The amount of the payment or other transfer of value.

(iv) The dates on which the payment or other transfer of value was provided to the covered recipient.

(v) A description of the form of the payment or other transfer of value, indicated (as appropriate for all that apply) as—

(I) cash or a cash equivalent;

(II) in-kind items or services;

(III) stock, a stock option, or any other ownership interest, dividend, profit, or other return on investment; or

(IV) any other form of payment or other transfer of value (as defined by the Secretary).

(vi) A description of the nature of the payment or other transfer of value, indicated (as appropriate for all that apply) as—

(I) consulting fees;

(II) compensation for services other than consulting;

(III) honoraria;

(IV) gift;

(V) entertainment;

(VI) food;

(VII) travel (including the specified destinations);

(VIII) education;

(IX) research;

(X) charitable contribution;

(XI) royalty or license;